

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 3000493

Facility Name: Wynscape Health Rehab

Address: 2180 Manchester Road Wheaton 60187
Number City Zip Code

County: DuPage

Telephone Number: 630-690-6662 Fax # 630-690-6004

HFS ID Number:

Date of Initial License for Current Owners: 12/17/2024

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Rob Schlicht Telephone Number: 414-431-9335
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)
(Type or Print Name) Emily Block
(Title) Administrator

Paid Preparer

(Signed)
(Print Name and Title) Rob Schlicht Director
(Firm Name & Address) Wipfli Advisory LLC 10000 Innovation Drive, Suite 250, Milwaukee, WI 53226
(Telephone) +1(414) 431-9335 Fax # 414-431-9303

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Wynscape Health Rehab # 3000493 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	209	Skilled (SNF)	209	76,285	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,285	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	242	184	0	0	12,368	3,323	1,690	17,807	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	242	184			12,368	3,323	1,690	17,807	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 23.34%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 12/17/2024

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 12/17/2024 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 199

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Wynscape Health Rehab # 3000493 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	1,027,576	10,148	2,408	1,040,132		1,040,132	(74,430)	965,702			1
2	Food Purchase		92,717		92,717		92,717		92,717			2
3	Housekeeping	528,943	45,363	716	575,022		575,022	(732)	574,290			3
4	Laundry											4
5	Heat and Other Utilities			405,988	405,988		405,988		405,988			5
6	Maintenance	441,639	54,179	413,926	909,744		909,744		909,744			6
7	Other (specify):*											7
8	TOTAL General Services	1,998,158	202,407	823,038	3,023,603		3,023,603	(75,162)	2,948,441			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,912,234	22,486	946,514	3,881,234		3,881,234		3,881,234			10
10a	Therapy			654,910	654,910		654,910		654,910			10a
11	Activities	136,658		14,054	150,712		150,712	(508)	150,204			11
12	Social Services	62,067		233	62,300		62,300		62,300			12
13	CNA Training	172,605		64	172,669		172,669		172,669			13
14	Program Transportation			20,478	20,478		20,478		20,478			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,283,564	22,486	1,660,253	4,966,303		4,966,303	(508)	4,965,795			16
	C. General Administration											
17	Administrative	389,441	13,854	937,654	1,340,949		1,340,949	(53,172)	1,287,777			17
18	Directors Fees											18
19	Professional Services			35,676	35,676		35,676	(13,774)	21,902			19
20	Dues, Fees, Subscriptions & Promotions			30,489	30,489		30,489		30,489			20
21	Clerical & General Office Expenses	154,717	1,930	489,888	646,535		646,535	(81,853)	564,682			21
22	Employee Benefits & Payroll Taxes			1,358,612	1,358,612		1,358,612		1,358,612			22
23	Inservice Training & Education											23
24	Travel and Seminar			31,530	31,530		31,530	(9,936)	21,594			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			377,819	377,819		377,819		377,819			26
27	Other (specify):*											27
28	TOTAL General Administration	544,158	15,784	3,261,668	3,821,610		3,821,610	(158,735)	3,662,875			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,825,880	240,677	5,744,959	11,811,516		11,811,516	(234,406)	11,577,110			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			211,017	211,017		211,017	99,117	310,134			30
31	Amortization of Pre-Op. & Org.			1,784	1,784		1,784	187,833	189,617			31
32	Interest			76	76		76	867,331	867,407			32
33	Real Estate Taxes							140,698	140,698			33
34	Rent-Facility & Grounds			4,871,410	4,871,410		4,871,410	(4,871,410)	0			34
35	Rent-Equipment & Vehicles			13,267	13,267		13,267		13,267			35
36	Other (specify):*											36
37	TOTAL Ownership			5,097,554	5,097,554		5,097,554	(3,576,431)	1,521,123			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			263,498	263,498		263,498		263,498			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	1,173		2,492	3,665		3,665		3,665			41
42	Provider Participation Fee			154,373	154,373		154,373		154,373			42
43	Other (specify):* AL/IL/Mktg			22,544,347	22,544,347		22,544,347	(22,544,347)	(0)			43
44	TOTAL Special Cost Centers	1,173		22,964,710	22,965,883		22,965,883	(22,544,347)	421,536			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,827,053	240,677	33,807,223	39,874,953		39,874,953	(26,355,184)	13,519,769			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(74,430)	1		4
5	Telephone, TV & Radio in Resident Rooms	(81,666)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(76)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(187)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(190,930)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(22,612,534)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,959,823)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,385,425)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,385,425)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (26,345,248)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	0	0	2
3	Transportation revenue	(508)	11	3
4	Other Income	(50)	17	4
5	Legal Fees	(13,774)	19	5
6	Employee Amenities - Meals	(9,103)	17	6
7	Flowers & Memorials	(1,247)	17	7
8	Housekeeping revenue	(732)	3	8
9	Marketing & Sales expense	(42,773)	17	9
10	Non SNF Expenses(AL,IL & Marketing)	(22,544,347)	43	10
11	allocate travel to IL	(9,936)	24	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(22,622,470)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Justliving Communities Corp.	100			NELP-Wyndemere LLC		Property Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental & Leasing	\$ 4,871,410	NELP-Wyndemere LLC		\$	(4,871,410)	1
2	V	33	Taxes - Real Estate		NELP-Wyndemere LLC		140,698	140,698	2
3	V	31	Amortization Expense		NELP-Wyndemere LLC		187,528	187,528	3
4	V	30	Depreciation Expense		NELP-Wyndemere LLC		290,047	290,047	4
5	V	32	Interest Expense - Non Operating		NELP-Wyndemere LLC		867,407	867,407	5
6	V	31	Financing Costs Amortization		NELP-Wyndemere LLC		312	312	6
7	V	31	Acquisition Costs		NELP-Wyndemere LLC		(7)	(7)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 4,871,410			\$ 1,485,985	\$ * (3,385,425)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wynscape Health Rehab # 3000493 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Wynscape Health Rehab # 3000493 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bonds Payable - LT #1	x					\$	48,610,000		8.5746	\$ 4,168,122	1
2	Bonds Payable - LT #2	x						48,390,000		8.5746	4,149,258	2
3	Bonds Payable - LT #3	x						10,630,000		8.5746	911,482	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	107,630,000			\$ 9,228,862	9
	B. Non-Facility Related*											
10								allocate to non snf entities			(8,361,455)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (8,361,455)	14
15	TOTALS (line 9+line14)						\$	107,630,000			\$ 867,407	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Wynscape Health Rehab

COUNTY

DuPage

FACILITY IDPH LICENSE NUMBER

3000493

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 05-18-304-021	Skilled Nursing Facility	\$ 228,237.24	\$ 228,237.24
2. 05-18-439-033	Senior Living	\$ 1,069,809.30	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,298,046.54	\$ 228,237.24

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,085 B. General Construction Type: Exterior Brick Frame Steel Number of Stories TWO

C. Does the Operating Entity? [X] (a) Own the Facility [X] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living (77 Units)
Independent Living (270 Units)

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: N/A 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	209		2025		\$ 780,020	\$ 5,201		\$ 5,201	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements		2025		3,521,279	12,189		12,189		11,908	9
10											10
11	Rental Property				10,998,348	290,047		290,047		290,047	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,299,647	\$ 307,437		\$ 307,437	\$	\$ 301,955	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	44,831	2,697	2,697		10	2,697	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 44,831	\$ 2,697	\$ 2,697	\$		\$ 2,697	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 15,344,478	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 310,134	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 310,134	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 304,652	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building	\$ 706,706	\$ 50,131	\$ 50,388	86
87	Equipment	432,159	26,010	26,010	87
88	Vehicle				88
89	Improvements - Building and Land	3,190,319	114,789	114,789	89
90	Land				90
91	TOTALS	\$ 4,329,184	\$ 190,930	\$ 191,187	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a - 3	hrs	\$	2,881	\$ 256,676	\$	2,881	\$ 256,676	1
2	Licensed Speech and Language Development Therapist	10a - 3	hrs		1,393	130,485		1,393	130,485	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a - 3	hrs		4,218	267,750		4,218	267,750	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	8,493	\$ 654,910	\$	8,493	\$ 654,910	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,927,055	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,231,498		3
4	Supply Inventory (priced at)	36,340		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,584,337		6
7	Other Prepaid Expenses	21,389		7
8	Accounts Receivable (owners or related parties)	71,695,976		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 79,496,595	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	780,020		14
15	Leasehold Improvements, at Historical Cost	3,521,279		15
16	Equipment, at Historical Cost	11,439,093		16
17	Accumulated Depreciation (book methods)	(211,017)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	148,100		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,553)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	532,715		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,202,637	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 95,699,232	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,873,797	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,035,564		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	69,636,333		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Wait list & Deposit	4,129,211		36
37	Accrued Expenses	55,891		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 80,730,796	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Lease & Loans	27,689,010		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 27,689,010	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 108,419,806	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (12,720,574)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 95,699,232	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(12,529,989)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(190,585)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (12,720,574)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (12,720,574)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wynscape Health Rehab

3000493

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,617,780	1
2	Discounts and Allowances for all Levels	(2,368,017)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,249,763	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,198,324	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,198,324	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	64,227	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	105,208	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,036	19
20	Radiology and X-Ray	6,552	20
21	Other Medical Services	39,541	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 227,564	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Independent & Assisted Living	20,669,313	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,669,313	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 27,344,964	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,023,603	31
32	Health Care	4,966,303	32
33	General Administration	3,821,610	33
	B. Capital Expense		
34	Ownership	5,097,554	34
	C. Ancillary Expense		
35	Special Cost Centers	22,811,510	35
36	Provider Participation Fee	154,373	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 39,874,953	40
41	Income before Income Taxes (line 30 minus line 40)**	(12,529,989)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (12,529,989)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 107,378.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer	426,883.00	47
48	Private Pay	3,272,893.00	48
49	Medicare Part A	1,436,377.00	49
50	Other-(specify)	6,234.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,249,765	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,400	3,640	\$ 493,925	\$ 135.69	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	13,629	15,146	810,614	53.52	3
4	Licensed Practical Nurses	3,277	3,624	153,587	42.38	4
5	CNAs & Orderlies	42,595	46,330	1,290,526	27.85	5
6	CNA Trainees	4,062	4,414	172,605	39.10	6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	5,553	6,280	136,658	21.76	10
11	Social Service Workers	1,332	1,408	62,067	44.08	11
12	Dietician			0		12
13	Food Service Supervisor	4,448	4,448	118,146	26.56	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	39,834	39,834	910,603	22.86	15
16	Dishwashers			0		16
17	Maintenance Workers	8,592	8,592	441,639	51.40	17
18	Housekeepers	17,161	18,831	528,943	28.09	18
19	Laundry			0		19
20	Administrator			0		20
21	Assistant Administrator			0		21
22	Other Administrative			0		22
23	Office Manager			0		23
24	Clerical	7,667	8,488	356,398	41.99	24
25	Vocational Instruction			0		25
26	Academic Instruction			0		26
27	Medical Director			0		27
28	Qualified ID Prof (QIDP)			0		28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records	2,014	2,277	163,583	71.84	31
32	Other Health Care(specify)			0		32
33	Other(specify)			0		33
34	TOTAL (lines 1 - 33)	153,564	163,311	\$ 5,639,294 *	\$ 34.53	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	176	\$ 9,768	1-3	35
36	Medical Director	192	24,000	9-3	36
37	Medical Records Consultant	44	3,281	10-3	37
38	Nurse Consultant	317	20,573	10-3	38
39	Pharmacist Consultant		13,825	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,400	11-3	44
45	Social Service Consultant	7	404	11-3	45
46	Other(specify) Admissions Consultant	NA	22,195	17-3	46
47	Interim DON	130	14,284	10-3	47
48	MDS Consultant	NA	3,470	10-3	48
49	TOTAL (lines 35 - 48)	905	\$ 114,198		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,943	\$ 386,856	10-3	50
51	Licensed Practical Nurses	831	51,778	10-3	51
52	Certified Nurse Assistants/Aides	5,614	219,031	10-3	52
53	TOTAL (lines 50 - 52)	11,388	\$ 657,665		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Jeff Hebreard	Director of Acctg.		\$ 164,777	Workers' Compensation Insurance		\$ 101,144	IDPH License Fee	\$ 3,806	
Judith Curatolo	Acctg. Assistant		68,180	Unemployment Compensation Insurance		38,704	Advertising: Employee Recruitment		
Genalyn Sommers	Billing Coordinator		91,039	FICA Taxes		420,462	Health Care Worker Background Check	7,415	
Angel Sanchez/Gabriel Davila	IT Tech		53,706	Employee Health Insurance		637,186	(Indicate # of checks performed _____)		
Patricia Grigg	HR Manager		121,437	Employee Meals			Employee Background Check/Fingerprinting/	14,771	
Parker Thomassen & Creyana Towner	HR Genarlist		130,678	Illinois Municipal Retirement Fund (IMRF)*			Software	11,848	
AL/IL Allocation			(240,376)	401k/403b Employer Match		111,601	Core Data Management Subscription	4,740	
TOTAL (agree to Schedule V, line 17, col. 1)				Physicals & Pre employment screenings		19,775	After hours on call physician subscription	9,270	
(List each licensed administrator separately.)			\$ 389,441	Misc benefits		29,742	CHUG Disaster Preparedness Network Dues	7,321	
B. Administrative - Other							AL/IL Allocation	(28,681)	
Description			Amount				Less: Public Relations Expense	()	
Employee Amenities			\$ 3,607				PAC and Lobbying payments	()	
Management Fee			862,880				All non-allowable advertising	()	
Marketing & Sales			42,773						
Other			28,393						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 937,654	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,358,612	TOTAL (agree to Sch. V, line 20, col. 8) \$ 30,489	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Amount		
Vendor/Payee	Type		Amount	Line #					
CliftonLarsonAllen LLP	Audit/Acctg		\$ 18,894				Out-of-State Travel	\$	
WIPFLI	Cost Report Preparation		1,352				Clinical Consultant Travels & Meals	3,290	
Bahr Anderson Law Group LLC	Legal		7,416				External Marketing Travel & Event Reimbur	1,297	
CAPITOL SERVICES	Legal		1,325				In-State Travel		
Holy & Schultz LLC	Legal		2,280						
McCarter & English LLP	Legal		4,978				AL/IL Allocation		
Polsinelli PC	Legal		14,999						
AL/IL Allocation			(15,568)				Seminar Expense		
							PCC Training Travel & Meals	14,727	
							Activities Director Travel & Meals	1,035	
							QC Audit Travels & Meals	1,245	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 35,676				TOTAL		\$ 21,594

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 22,486

Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 154,373

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 64,227
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

Yes

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: RSM US LLP

Yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.